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Chief Executive Officer

July 1, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

KATIE A. IMPLEMENTATION PLAN QUARTERLY UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003);
- Enhanced Specialized Foster Care Mental Health Services Plan (2005);
- Findings of Fact and Conclusions of Law Order (2006), issued by Federal District Court Judge Howard Matz;
- Health Management Associates Report (2007); and
- Katie A. Corrective Action Plan (2007).

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

KATIE A. STRATEGIC PLAN OBJECTIVES	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services	4. Training
5. Caseload Reduction	6. Data/Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

The Strategic Plan also provides that the Departments of Children and Family Services (DCFS) and Mental Health (DMH) inform your Board regarding any revisions to the implementation of the Strategic Plan and report quarterly thereafter. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan (CAP), this report will also describe any significant deviations from the planning described in those documents. The Departments conducted an annual assessment in January 2010 to evaluate the effectiveness of Strategic Plan implementation, plan financing, and status of efforts to maximize revenue reimbursement.

Previous quarterly reports were submitted on implementation activities in June 2009, September 2009, and March 2010. This memo serves as the fourth update to our progress in implementing the Strategic Plan.

Implementation Support Activities

- Greg Lecklitner, DMH District Chief, continues to participate as a member of the Katie A. State Negotiations Team, which is working toward a settlement of the Katie A. State Case;

- The DCFS Bureau of the Medical Director is hosting a series of four "D-Rate Town Hall" meetings throughout the County and has invited all foster parents, relative caregivers, and adoptive parents to attend. The goal of these meetings is to have a dialogue with caregivers about the D-Rate Program and to understand the difficulties faced when meeting the needs of children for whom they are responsible;

- DCFS, Department of Health Services, DMH, and the Chief Executive Office (CEO) managers have met with five of the seven Medical Hubs: High Desert Health System Multi-Service Ambulatory Care Center, Harbor-UCLA Medical Center Hub, Children's Hospital Los Angeles, LAC+USC Medical Center Hub, and Martin Luther King Jr. Multi-Service Ambulatory Care Center. The LAC+USC East San Gabriel Valley Satellite Hub visit is scheduled for August 25, 2010, and the Olive View-UCLA Medical Center Hub visit is scheduled for August 31, 2010. The Hub meetings are held to increase collaboration, ensure a strong understanding of Hub operations and to plan for improved access and service delivery;

- DCFS continues to develop and maintain the Katie A. Website;

- DCFS has now hired 80 of the 81 positions allocated in the Strategic Plan, and DMH has hired 36 of the 42 positions allocated; and

- Department representatives participated in a two and a half day meeting with the Katie A. Advisory Panel in May 2010 to discuss the Core Practice Model (CPM), Qualitative Services Review (QSR), Multidisciplinary Assessment Team (MAT) case review and overall Strategic Plan Implementation issues.

Additional implementation activities associated with the Strategic Plan, organized according to the basic elements of the Plan are described below.

OBJECTIVE NO. 1

Mental Health Screening and Assessment

The Strategic Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health service needs. Below are the Screening and Assessment components of the Plan:

- *Medical Hubs* • *Coordinated Services Action Team (CSAT)* • *MAT* • *Referral Tracking System (RTS)* • *Consent/Release of Information* • *Benefits Establishment* • *D-rate* • *Team Decision-Making (TDM)* • *Resource Management Process (RMP)* • *Specialized Foster Care (SFC)*

Medical Hubs:

From July 2009 through February 2010, 82 percent of newly detained children received an initial medical examination at a Hub.

DCFS continues to improve child health outcomes for DCFS children by ensuring that 100 percent of the priority populations of DCFS children are referred to and served by the Medical Hubs. In June 2010, the DCFS Medical Director issued a memorandum to all DCFS staff defining the priority populations as:

- Newly detained children placed in out-of-home care;
- Children who are in need of a forensic evaluation to determine abuse and/or neglect; and
- Children with special health care issues that need a follow-up exam, i.e., diabetes, hemophilia, developmental delay, etc.

As a result, the DCFS' utilization of Medical Hubs' Procedural Guide will also be revised to align the priority populations with the memorandum.

In addition, the County has taken steps to improve the continuity of care from the Medical Hubs and has begun the development and implementation of an Enterprise Medical Hub (E-mHUB) system. The E-mHUB system will record the healthcare information of all DCFS children and allow information sharing between all Medical Hub sites and DCFS.

The E-mHUB system agreement was approved by your Board on March 30, 2010, and the sole source agreement with Sega Technology Inc. was executed in May 2010. An E-mHUB Project Workgroup has convened to ensure that the vendor meets its deliverables.

CSAT Redesign Roll-Out and Training Schedule:

On May 1, 2009, CSAT was implemented in Service Planning Area (SPA) 7 (Belvedere and Santa Fe Springs). On August 1, 2009, CSAT was implemented in SPA 6 (Compton, Wateridge and Vermont Corridor). SPA 1 (Lancaster and Palmdale) implemented CSAT in September 2009, and SPA 3 (El Monte and Pomona) implemented CSAT on April 1, 2010.

In response to the January 19, 2010 motion from Supervisors Molina and Knabe, DCFS and DMH staff reviewed a sample of 51 children's cases from the DCFS Santa Fe Springs Regional Office for mental health screening, referral, and start of mental health services. The cases were randomly selected from newly detained children (25 cases) and newly opened non-detained children (26 cases).

The case review revealed several areas of needed improvement to bring the Departments into full compliance with best practice child welfare mental health standards. The screening tool will be revised to improve its sensitivity in identifying children with mental health needs and to triage children according to acute, urgent, or routine mental health needs. The revised Child Welfare Mental Health Screening Tool (MHST) was specifically designed to be administered by DCFS Children's Social Workers (CSWs).

The new MHST was piloted in the following CSAT implemented offices: SPA 7 (Belvedere and Santa Fe Springs); SPA 6 (Compton); SPA 1 (Lancaster and Palmdale); and SPA 3 (El Monte) from May 11, 2010 to May 28, 2010. The primary differences between the previous and new MHST includes the indication of acuity, the elimination of severe symptoms as a requirement to meet criteria for a positive mental health screen and the addition of parenting abilities for children age 0-5 years. The acuity measure reflects the child's need for a mental health assessment as acute, urgent, or routine.

The pilot sample consisted of 17 completed MHSTs. Pilot results revealed that 76 percent of the CSWs felt that the new MHST was easier to complete and 77 percent were able to complete the new MHST within 0–15 minutes. Upon further modification based on the

feedback received, the new MHST will be instituted following CSAT Training according to the CSAT implementation schedule in all DCFS Offices.

DCFS policy will be amended to require Emergency Response (ER) CSWs to complete the MHST for any child in conjunction with the promotion of a DCFS case and to contact the DMH Psychiatric Mobile Response Team (PMRT) when children appear to be in immediate need of mental health services. Co-located DMH staff will primarily respond when children present with urgent or routine mental health needs.

Policy and procedures are in place to serve children with acute and urgent mental health needs, moreover DMH and DCFS are working to enhance urgent psychiatric care and crisis stabilization for DCFS involved children. DMH is exploring future collaboration with two urgent care centers already in existence through Exodus (LAC+USC and Culver City) as an additional mental health resource for DCFS children with acute or urgent mental health needs.

DCFS CSWs currently "informally" re-screen children at each home visit, but "formal" re-screenings on an annual basis are needed to systematically ensure children with mental health needs are identified on an on-going basis. Policy will be amended to require CSWs to complete annual re-screenings of children who screened negative at case opening and are not receiving mental health services.

The Medical Hubs will continue to complete mental health screenings using the established process and original MHST as a back-up or safeguard to screenings being completed by DCFS CSWs. After Countywide implementation of CSAT and the MHST, the Departments will revisit the Medical Hub's screening process to determine if the revised MHST will be implemented at the Medical Hubs and/or what other procedural changes may be needed to increase efficiencies and quality of service.

In total, a redesign of the MHST, DCFS, and DMH policies and procedures, tracking system, and training curriculum are currently underway. The redesign has delayed the roll out of CSAT to DCFS Offices not yet trained. Those offices already trained and implementing CSAT (SPAs 1, 6, 7, El Monte, and Pomona) will be retrained and will implement the new procedures first, followed by the remaining offices.

The training roll out per office is depicted in Table 1.

Table 1: CSAT Redesign Training and Roll-Out Schedule

DCFS Office	Training Month	Trial Month	CSAT Roll Out	Referral Tracking System Report to Board
Belvedere, SFS	Aug. 2010	Sept. 2010	Oct. 2010	Dec. 2010
Compton, Wateridge, Vermont Corridor	Aug. – Sept. 2010	Oct .2010	Nov. 2010	Jan. 2011
Palmdale, Lancaster	Sept. – Oct. 2010	Nov. 2010	Dec. 2010	Feb. 2011
Pomona, El Monte, Pasadena, Covina Annex (Asian Pacific & American Indian Units Only)	Oct. – Nov. 2010	Dec. 2010	Jan. 2011	Mar. 2011
Glendora	Nov. – Dec. 2010	Jan. 2011	Feb. 2011	Apr. 2011
Metro North	Dec. – Jan. 2011	Feb. 2011	Mar. 2011	May 2011
West Los Angeles (and Deaf Services)	Jan. – Feb. 2011	Mar. 2011	Apr. 2011	June 2011
Lakewood, Torrance	Feb. – Mar. 2011	Apr. 2011	May 2011	July 2011
San Fernando Valley, Santa Clarita	Mar. – Apr. 2011	May 2011	June 2011	Aug. 2011
Medical Case Mgmt. Services	May 2011	June 2011	July 2011	Sep. 2011
Emergency Response Command Post	May 2011	June 2011	July 2011	Sep. 2011

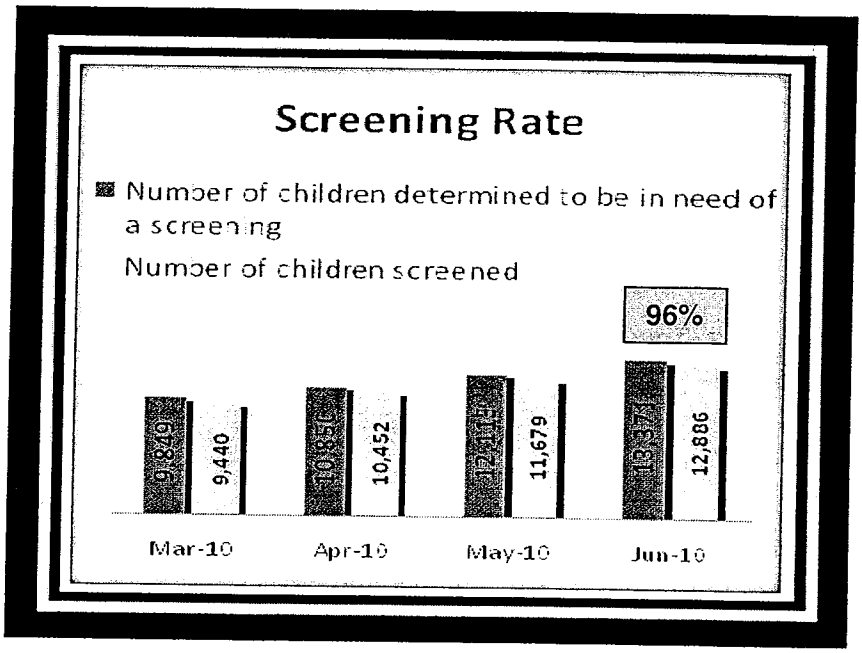
CSAT SUCCESS STORY

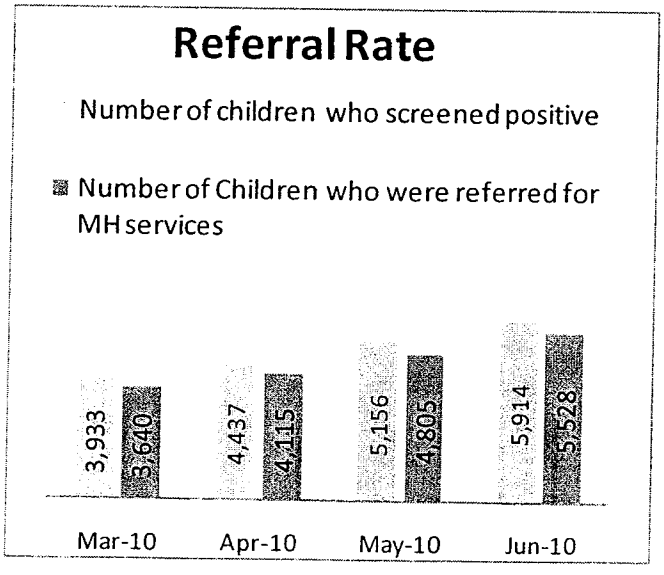
A 21-year-old youth's transitional plan to live in a Regional Center Board and Care facility following DCFS supervision was delayed after he was denied Social Security Income (SSI) benefits due to a missed appointment with the Social Security Administration (SSA). Additionally, his Medi-Cal benefits were interrupted, impacting his ability to pay for his medication. The Service Linkage Specialist (SLS) worked closely with the CSW, caregiver, SSA, and Regional Center to resolve his SSI status and reactivate his Medi-Cal. The youth's SSI was approved, Medi-Cal was reactivated, and his medication costs were

covered. At the transition conference, it was determined that the Regional Center would assume funding for residential placement upon receipt of a court order for the youth's emancipation and successful transition from DCFS jurisdiction.

RTS

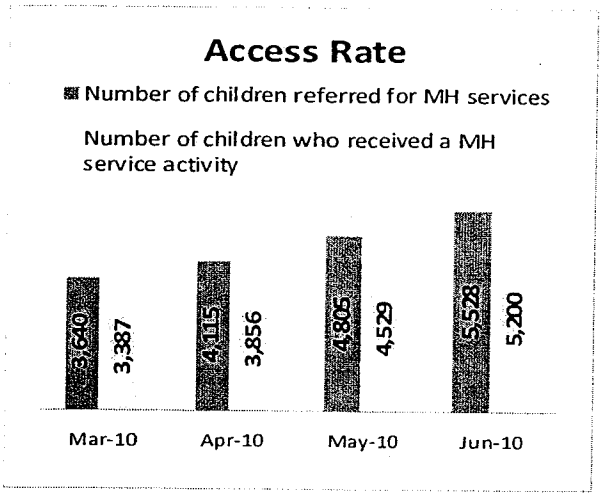
The RTS is currently operational in DCFS and DMH in a total of nine DCFS Regional Offices in SPAs 1, 3, 6, and 7. As of the June 30, 2010 CSAT/RTS Monthly Report, 12,886 children received mental health screens since implementation on May 1, 2009 and were tracked through the RTS for referral and mental health service linkage.





- As of the June 30, 2010 Monthly Report, out of the **5,914** children who screened positive, **5,528** children were referred for mental health services at a **96 percent** referral rate.

- As of the June 30, 2010 Monthly Report, out of **5,528** children referred for mental health services, **5,200** children received a mental health service activity within 30 days of the referral at a **94 percent** access rate.



MAT

In April 2010, 83 percent of all MAT eligible newly detained children Countywide were referred to MAT. From October 2009 to April 2010, there were 2,559 MAT referrals and 2,057 MAT assessments completed.

In April 2010, 12 DCFS Offices referred 90 percent to 100 percent of all MAT eligible children. Six offices referred between 70 percent and 80 percent of all MAT eligible children – only one office is currently below 70 percent. Six of the eight SPAs are referring over 70 percent of eligible children. SPA 1 referral rates lag behind due to provider capacity issues. The rate of MAT compliance is depicted in Table 2.

Table 2: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	48	29	60%
SPA 2	65	61	94%
SPA 3	92	84	91%
SPA 4	32	29	91%
SPA 5	7	7	100%
SPA 6	87	58	67%
SPA 7	78	65	83%

SPA 8	65	62	95%
Total number of DCFS MAT referrals:	**474**	**395**	**83%**

*Cumulative includes all April 2010 MAT referrals within each DCFS office and SPA.

MAT staff (DMH, DCFS, and MAT agencies) meet at the SPA level on a monthly basis to address MAT issues specific to the regional office and the providers in that SPA. A MAT Operations Workgroup, composed primarily of experienced MAT providers, DCFS and DMH managers, is working to standardize and streamline the MAT process, improve the quality of MAT reports and overcome barriers that prevent MAT agencies from completing the Summary of Findings (SOF) Report in time to be considered by the Court for the dispositional hearing. DCFS MAT Coordinators are closely monitoring the dispositional date of cases referred for MAT and are sending reminders of the date to the agencies. DCFS MAT Coordinators work closely with the Dependency Court attorneys to ensure that children have the appropriate consents to receive needed services.

DMH and DCFS have issued a MAT Program Practice Guidelines document that outlines the scope of work for MAT providers, quality improvement protocol, MAT checklist, and MAT CSW Interview Survey. These protocols are now being implemented in an effort to evaluate and improve the quality of the MAT program. DMH and DCFS are also convening a MAT Best Practices Workgroup to further refine the assessment process and ensure the MAT SOF Report is completed in line with recommendations made by the Children's Services Investigation Unit.

To date, DMH MAT Coordinators have completed a total of 154 MAT Quality Improvement (QI) checklists. The checklists represent their findings based upon a review of the MAT SOF. QI checklists were received from the eight SPAs. The MAT QI checklist calls for yes/no responses within eight domains. The results of the MAT QI checklists are summarized below.

Results within MAT QI domains:

1. 85 percent of the SOFs reviewed showed that the assessors demonstrated reasonable efforts to engage all the stakeholders in multidisciplinary activities to support the information gathering/assessment process;

2. 83 percent showed the SOF report adequately assessed all of the MAT domains of functioning;

3. 87 percent showed the SOF reports contained adequate description and information;

4. 88 percent showed the SOF final report was completed within 45 days;

5. 95 percent showed the strengths of the children, family, and other caregivers were adequately described;

6. 90 percent showed the needs of the children, family, and other caregivers were adequately described;

7. 92 percent showed the recommendations made in the report were consistent with the assessment information; and

8. 96 percent showed the recommendations were specific enough to be efficiently implemented.

Overall, 90 percent of the individual domain ratings were positive.

This was a high-needs sexual abuse case that required a Resource Utilization Management (RUM) assessment and linkage to Wraparound. The MAT Coordinator worked with the RUM Worker to expedite the RUM referral without having to hold an additional meeting with the family. The MAT Coordinator suggested that the RUM Worker complete the Child and Adolescent Needs and Strengths (CANS) tool with information from the MAT SOF Report and any additional interviews. The MAT Coordinator also helped secure the children's acceptance to the Wraparound program.

Consent/Release of Information

DCFS and DMH, with their respective County Counsels, have developed procedures and forms to provide for the consent of mental health services for referred children, as well as the authorization to release protected health information for purposes of children's care and coordination of services. Recommendations from children's and parents' attorney groups were incorporated and the pending revisions have been approved by the Children's Law Center, the Los Angeles Dependency Lawyers, County Counsel, DMH, and DCFS management. In addition, all parties approved standardized language that CSWs can insert into court reports to obtain consent from the courts when they are unable to secure parents' signatures. The DCFS training section will train service providers and staff from both Departments on the revised consent and release of information forms and provide guidance as to which information can and cannot be shared.

DCFS has also consulted with Regional Center in an effort to ensure that DCFS policies appropriately address the needs of all children. As a result, DCFS has learned that current policies on developmental needs and services will need to be revisited. Regional Center

management has agreed to attend the Consent Project Team meetings to provide consultation on appropriate requirements and procedures.

The DMH Practice Guidelines related to consultation requests involving adult mental health information is completed and being reviewed by County Counsel prior to being vetted by both Departments. The Guidelines include information on the formation of multidisciplinary teams that may allow DMH co-located staff and service providers to share adult caregiver mental health information to assist DCFS in providing protection to children and support to families. DCFS has agreed to create a comparable policy to clarify which situations merit consultation with DMH and what information can be shared within this context.

Benefits Establishment

In August 2009, the CSAT team of MAT Coordinators, SLS, and CSAT clerks were given access to the MEDSLITE benefits establishment system. MEDSLITE is a condensed version of the Medical Eligibility Determination System (MEDS) that assists its users in quickly determining a child's Medi-Cal eligibility status. DCFS has developed a Benefits Establishment User Guide for SLS and MAT Coordinators that serves as an instructional guide for the use of MEDSLITE, incorporating information that applies to programs available to DCFS families. The timely determination and accuracy of a child's benefits assist the DCFS and DMH staff to link an identified child to the most appropriate mental health services for all new and existing cases for CSAT implemented offices.

Although the MEDSLITE system is helpful in providing a child's Medi-Cal eligibility status, "at a glance" one of the limitations to the system is that it does not provide the issue date of a child's Medi-Cal card, needed most by DMH providers for mental health service billing.

Also, in some cases, Medi-Cal benefits have been erroneously discontinued when children are replaced. In an effort to avoid such problems, this group is currently targeting the systemic problems that result in lapses in children's Medi-Cal benefits to help ensure ongoing and timely health services.

D-rate

In addition to the D-rate Program's continued work to review and ensure mental health services for at least 81 percent of D-rate children, the duties of the DCFS D-rate Evaluators (DREs) have been expanded to include psychotropic medication monitoring for all DCFS children, psychiatric hospital discharge planning, special placement requests and approvals, and service coordination for other high-need children.

Over 3,000 Pyschotropic Medication Authorization (PMA) Reports have been submitted to Court by DREs in the last 15 months on the perceived effects of psychotropic medications on children under Juvenile Court supervision. Additionally, the D-Rate Program received an

assignment to ensure that all youth in Foster Family Agencies that are taking psychotropic medication were contacted for follow-up from February through April 2010. DREs reviewed 626 cases of children identified by CWS/CMS as having current psychotropic medication. Of the 626 children, only 380 were taking psychotropic medication. Of these children, 91 percent were taking medication as prescribed with current PMAs on file, and eight percent (29 children) were taking medication with no current PMA on file.

TDM/RMP

DCFS has completed 4,427 TDMs from January through March 2010. This was an increase of 208 TDMs from the previous three months (October through December 2009). Additionally, DCFS completed a total of 449 RMPs with 67 percent of youth entering a group home, 69 percent of youth replaced and 59 percent of youth exiting a group home. This was an increase of 83 RMPs from the previous three months (October through December 2009).

Finally, DCFS continues efforts to phase in TDMs at the Emergency Response Command Post (ERCP). There were a total of 29 TDMs completed. Preliminary data reflects positive outcomes: 18 (62 percent) of the ERCP TDMs resulted in children remaining home with their respective caregivers; and 21 (72 percent) of the ERCP TDMs convened had the participation of community-based agency partners.

SFC

The DMH Child Welfare Division/DMH co-located staff responds to requests for consultation from DCFS CSWs, provides referral and linkages to community-based mental health providers, and participates in the CSAT process in those offices where CSAT has rolled out. Moreover, all SFC co-located staffs (a total of 70 clinicians) have been trained in Trauma-Focused Cognitive Behavior Therapy, a brief evidence-based treatment for children exposed to trauma, and provide this treatment on a case-by-case basis. Currently, DMH has 178 co-located staff in 18 DCFS Regional Offices.

OBJECTIVE NO. 2

Mental Health Service Delivery

DMH has been working with its provider community to improve capacity and utilization of mental health services, particularly among those providers, now totaling 64, who have received a Katie A. related contract (including Wraparound, MAT, Treatment Foster Care, Comprehensive Children's Services Program, and Basic Mental Health Services). In total, these contracts provide for over $97 million of targeted mental health services for DCFS children. In addition to these targeted contracts, DMH children's providers also use their general service contracts to provide needed services to DCFS children. We anticipate that

the total Early Periodic Screening Diagnosis and Treatment (EPSDT) expenditures related to the provision of mental health services for DCFS children will reach approximately $300 million for Fiscal Year (FY) 2009–10.

A memorandum was issued by DMH Director, Marvin J. Southard, encouraging these providers to maximize their contract utilization on behalf of DCFS involved children. To support this effort, DMH has encouraged a flexible approach to the utilization of Katie A. related allocations, consistent with good mental health practice, in providing mental health services to DCFS involved children and has made the necessary adjustments in the DMH Integrated System to track these expenditures. Furthermore, DMH District Chiefs are provided with monthly reports which track Katie A. related allocations and expenditures among the DMH contract providers.

Wraparound

On May 1, 2009, the County began implementation of Tier II Wraparound, an expansion of the existing Wraparound Program.

As of April 30, 2010, 1,048 children are enrolled out of a maximum total of 1,400 available slots in Tier I Wraparound, and for the first time ever since the roll out of Tier II, 887 children are enrolled in Tier II Wraparound as of May 2010, exceeding the cumulative target by 12 slots.

In March 2010, the Departments issued a directive that allowed Tier I Wraparound providers the opportunity to self-refer up to ten children to enroll in Wraparound. Based on the positive results in May, the ten child self-referral pilot was moved to a permanent option and it included Tier II. As mentioned in the last update, the County explored the option of eliminating the rotation process to providers for referrals, however, it was decided that the rotation will remain in place after meeting with the providers. A more recent effort to increase Wraparound referrals is a "rule in" for Wraparound whenever there are mental health issues present. Wraparound and the CSAT have partnered to ensure all youth are considered for Wraparound.

Treatment Foster Care (TFC)

The County's TFC Program is another intensive mental health service program, originally discussed in the Katie A. CAP. Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge, Howard Matz, the County was directed to develop 300 TFC beds by January 2008. A proposal to develop 300 beds by December 2012 was established as the new target. The TFC Program, which includes a planned 220 beds of Intensive Treatment Foster Care (ITFC) and 80 beds of Multi-dimensional Treatment Foster Care (MTFC), continues to make slow but steady progress in bed development, program implementation, placement, and interagency collaboration.

The primary challenge with TFC remains with bed development. On June 15, 2010, the TFC program had a total of 43 certified TFC foster homes; one less than the projected target of 44 beds. This growth is directly related to the nine agencies moving forward in the implementation of their TFC teams. Each has hired and trained all team members, including the evidence-based training for their clinicians through DMH in Trauma Focused-Cognitive Behavioral Therapy and/or Multi-dimensional Treatment Foster Care. Three additional Foster Family Agencies are expected to reach full implementation of their TFC teams by July 2010.

As of 6/15/2010

Agency	Total # of Placed Children	Total Certified Homes	Certified Homes Vacancies	**Certified Homes on Hold	Upcoming Beds (cert. incomplete)
Intensive Treatment Foster Care (ITFC)					
Five Acres	10*	11*	1	2	7
ChildNet	5	7	0	2	2
Olive Crest	1	2	0	1	0
Penny Lane	0	0	0	0	6
Aviva	0	0	0	0	0
Rosemary's Children Serv.	0	0	0	0	0
The Village	1	4	2	1	4
CII	0	0	0	0	6
David and Margaret	0	0	0	0	4
SUB TOTAL	17	24	3	6	29
Multi-dimensional Treatment Foster Care					
CII	3	7	2	2	0
Penny Lane	1	7	4	2	9
ChildNet	0	5	5	0	0
David and Margaret	0	0	0	0	2
SUB TOTAL	4	19	11	4	11
GRAND TOTAL	**21**	**43**	**14**	**10**	**40**

* Three children placed in one ITFC home

**Per Agency request

DMH has added capacity within the MTFC program to serve children as young as six years old. DMH has also expanded MTFC capacity from two SPAs to five SPAs. With the TFC teams in place, the agencies are now tackling the time-consuming task of recruiting, certifying and training TFC foster parents. TFC program staff is assisting in recruitment with more proactive outreach to existing licensed foster parents that might be interested in working with the TFC target population.

DMH has contracted with UCLA to partner on a three-year research project which will examine the use of various evidence-based practices for children and adolescents as compared to usual or conventional treatment approaches. This project, known as ChildSTEPs, will provide substantial training, consultation and technical assistance, and tracking of outcomes for those mental health providers participating in the study and will inform future planning of children's mental health services.

DMH has also begun a large scale transformation of mental health services related to the Mental Health Services Act Prevention and Early Intervention Program. As part of this initiative, children's mental health providers are being trained in a variety of evidence-based practices, including Trauma-Focused Cognitive Behavior Therapy, Triple P (Positive Parenting Program), Child Parent Psychotherapy, Depression Treatment Quality Improvement (DTQI), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Managing and Adapting Practice (MAP), and Seeking Safety.

OBJECTIVE NO. 3

Funding of Services/Legislative Activities

All three Departments are closely monitoring expenditures this fiscal year and similar to previous years, there will be savings, primarily stemming from vacant Wraparound slots. Currently, we anticipate approximately $20 million in fiscal year savings from 2009-10. CEO recommends, as we did with the FY 2008-09 savings, rolling the FY 2009-10 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2011-12 in support of the incremental roll out of the Strategic Plan.

Since the beginning of this year, Tier II Wraparound enrollments have increased by 52 percent. Moreover, for the first time since the roll out of the Tier II slots in May 2009, Tier II enrollments for May 2010 exceeded the monthly target. If the upward trajectory of filling Wraparound slots continues, the proportion of Katie A. savings will decline in the out years.

The Special Master in the State portion of the Katie A. case filed a report with the Court on May 28, 2010. The Court has accepted the Special Master's Report and is extending his appointment through November 2010 in order to clarify positions, narrow differences, and reach agreements between the State and Plaintiffs. Notably, much of the County's service

delivery philosophy and selection of intensive home-based mental services detailed in the Strategic Plan has been incorporated in the Special Master's Report. Weekly negotiations between the parties will resume in July, and DMH will continue to represent the County in these discussions. As previously discussed, the County's continued participation in the Court mediated negotiations between the Plaintiffs and State remains the County's most viable opportunity to maximize revenue reimbursement to the County.

OBJECTIVE NO. 4

Training

A draft of the joint DMH/DCFS CPM was presented to the Katie A. Panel on May 11, 2010. It included input from 85 focus groups, community stakeholders, as well as the wisdom of 13 other States' Core Practice Models. The CPM will serve to align the two Departments and the continuum of providers in the identification of children's needs and strengths. The CPM will incorporate teaming across traditional role boundaries to support the provision of services to meet the needs of children and families, and in implementing coaching/mentoring models to support practice improvement consistent with the elements of the QSR.

The California Institute of Mental Health (CIMH) also made a presentation to the Panel regarding the assistance they are providing to DMH in developing the core mental health competencies associated with the CPM and initiating a training program for DMH co-located staff and contract providers. The training will also include skill building in providing intensive home-based services and trauma-informed practice. The CIMH contract will also provide training for the ITFC providers and Full Service Partnership providers in Trauma-Focused Cognitive Behavior Therapy.

DMH and DCFS have worked closely together to develop and implement the necessary training components relating to the Strategic Plan, including:

- All DCFS Line Supervisors have been asked to attend one of the four one-day Supervising CSW conferences. They will be introduced to a Coaching and Mentoring training as part of the shared CPM to enhance family engagement and practice to promote good outcomes for children and families. The first Supervisor Conference was held June 15, 2010;

- All DCFS Offices (with the exception of Lakewood, Santa Fe Springs, and Belvedere) have received Wraparound training. The remaining offices will be trained by September 2010; and

- The Enhanced Skill-Based Training Pilot begins in July 2010. This training consists of three two-day modules. Model 1: "A Culturally Strength-Based Approach" will be

held July 13–14, 2010. Model 2: "Effective Engaging" will be held on July 21–22, 2010. Model 3: "Teaming with Families" will be held July 28–29, 2010.

OBJECTIVE NO. 5

Caseload Reduction

The DCFS total out-of-home caseload has been reduced from 15,748 (May 2009) to 15,680 (January 2010). As of May 2010, the total out-of-home caseload has decreased to 15,405.

Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanency and well-being.

As of January 2010, individual CSW generic caseload sizes have been reduced from an average of 26 to 22.48. A slight increase in this average in May 2010 brought the average caseload to 24.94 children per social worker.

As of January 2010, the ER caseload was reduced from an average of 24 to 19.25. This service component also experienced a slight increase through May 2010, bringing the current referral average to 19.72. The increased trend in caseload and referral averages is due to the increased number of ERCP referrals received within the past six months, increased workload tied to heightened safety measures in emergency response activities and investigations, and the need to address an increasing backlog of emergency response investigations.

OBJECTIVE NO. 6

Data and Tracking of Indicators

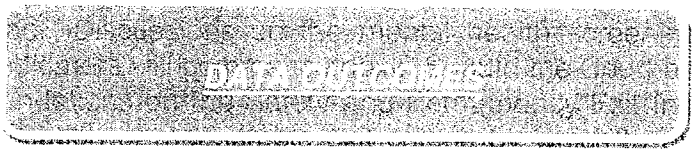
The Departments, with approval from County Counsel, implemented a plan for sharing protected data sources to track all DCFS referrals for mental health services and provide information regarding service delivery. The SAS Dataflux system is being used for matching DMH and DCFS client data. The software has undergone extensive parallel testing, with the assistance of the Internal Services Department, to improve the validity of client matches. It is anticipated that the SAS Dataflux system will be in full production by August 2010, whereby matches can be conducted more frequently, potentially on a monthly or weekly basis.

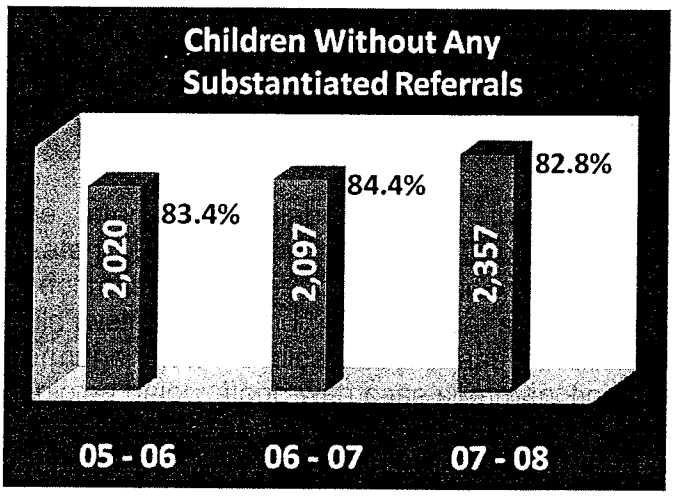
As previously discussed in the last quarterly report, the County and the Panel tentatively reached agreement on a set of Safety and Permanency Exit Indicators to track and targets to be maintained for duration of time to achieve compliance with this aspect of the exit criteria. At the end of March 2010, the agreement was solidified and the Katie A. Panel

agreed to attach the Safety and Permanency Exit Indicators to their next report in July 2010 for Court consideration. Discussions on the mental health screening, assessment, and service delivery exit indicators will commence next. Should the Court agree with the County and Panel's recommendations on the Safety and Permanency Exit Indicators and targets, the first step in identification of measurable exit criteria by which to evaluate the County's progress in complying with the Katie A. lawsuit would be accomplished.

SAFETY	PERMANENCY/REDUCED OUT-OF-HOME CARE	WELL-BEING	SELF-SUFFICIENCY

The intensified collaboration of the departments to advance the objectives of the Strategic Plan is simultaneously impacting DCFS key goals to: 1) improve child safety; 2) decrease timelines to permanency and reduce reliance on out-of-home care; 3) improve child well-being; and 4) enhance self-sufficiency. A sampling of Katie A. Safety and Permanency Exit Indicators for class members (those receiving mental health services) are depicted below along with case summary findings from a quality assurance review of mental health records and a data indicator demonstrating improvement in safe and affordable housing upon service termination for those enrolled in the Independent Living Program.





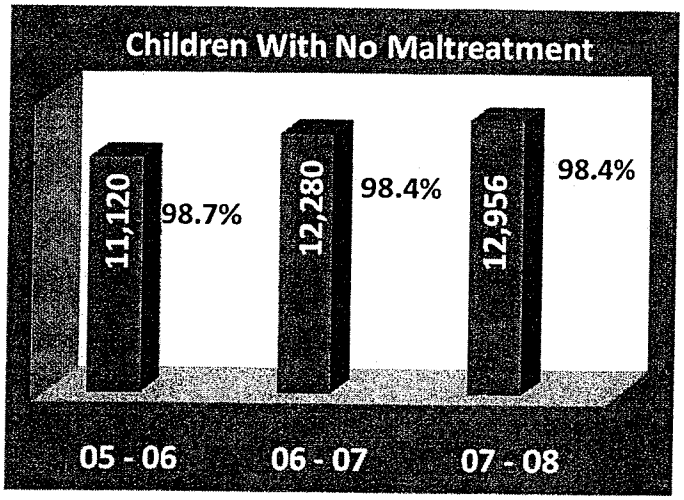
Safety Indicator 1:

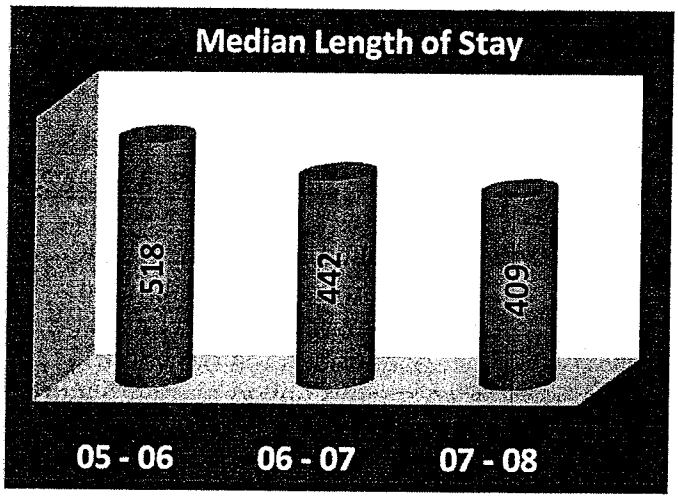
Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.

This indicator has remained fairly stable over the last few years at roughly 84 percent and demonstrates that the majority of children are remaining safely at home.

Safety Indicator 2:

Of all children served in foster care in the fiscal year receiving mental health services, how many did not experience maltreatment by their foster care providers? Again, this indicator has remained stable at 98 percent indicating that the majority of children in foster home settings experienced no substantiated foster parent maltreatment.



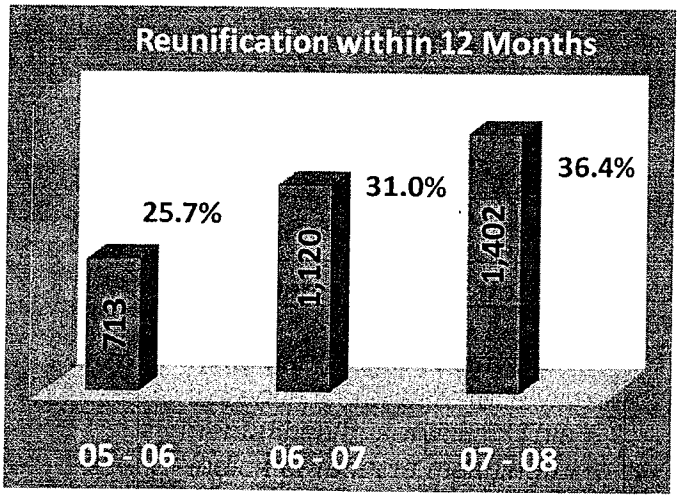


Permanency Indicator 1:

Median length of stay for children in foster care receiving mental health services. This indicator reflects meaningful improvement – a 21 percent decline – in median days in foster care from FY 2005-06 to FY 2007-08.

Permanency Indicator 2:

Reunification within 12 months for children receiving mental health services. Dramatic improvements in reunification are evident – a 97 percent increase from FY 2005-06 to FY 2007-08.



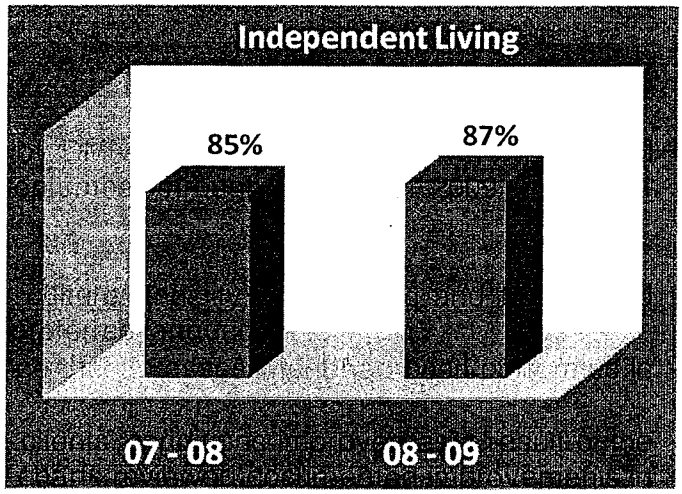
(Well-Being) Quality of Mental Health Services

A quality assurance chart review conducted by DMH for 43 DCFS children referred to and receiving mental health services between September through December 2009 in SPAs 1 and 6, revealed the following:

- All 43 charts reviewed identified the culture/ethnicity of the child and family and provided services in the child/family's preferred language;
- All 43 charts reviewed showed evidence that an assessment had been performed in a timely manner;
- 39 of the 43 charts indicated that the clients' conditions improved as a result of the mental health services received. The charts reviewed documented improvements in children's coping skills, school performance, and relationships with peers and family members; and
- 34 of the 43 charts indicated that children received mental health services in a home or school setting.

Self Sufficiency:

Percent of foster youth who received Independent Living Program (ILP) services and are living in safe and affordable housing upon service termination at age 21. The majority of youth participating in ILP do transition to safe and affordable housing upon service termination. The rate slightly increased in FY 2008-09.



OBJECTIVE NO. 7

Exit Criteria and Formal Monitoring Plan

The Strategic Plan identifies three formal exit criteria, including the successful adoption by your Board and the Federal District Court of the Strategic Plan, acceptable progress on a discrete set of agreed upon data indicators and a passing score on the QSR.

The conceptual framework of the Katie A. five-year Strategic Plan has been approved by your Board, Panel, and Plaintiffs' attorneys, and, as previously noted, the Strategic Plan was approved by the Federal District Court on July 22, 2009. This notes the first time since the inception of the lawsuit that a County developed plan for Katie A. has been approved by the Court, which is a significant achievement in itself for the County and identifies a practical timeline with objective criteria for exiting the lawsuit.

The QSR process will take place in three phases. Phase I calls for the development of a tailored QSR instrument, the identification of staff responsible for the development of the protocol, the identification of training resources, the identification of and training of lead reviewers, and the development of a QSR implementation plan. These activities are expected to be completed by July 2010.

Phase II, to be completed between September 2010 and December 2012, commences the administration of the QSR across the 18 DCFS Regional Offices; while Phase III, to be completed by December 2013, consists of any follow-up reviews that may be necessary to achieve passing scores.

Key child and family status and system performance indicators have been identified to comprise our Los Angeles County customized QSR protocol. Between March and May of 2010, a technical review of the draft protocol had been conducted and a refined pilot review version of the Protocol was finalized for pilot testing. Advance preparations have also been underway to identify the initial sequence of offices to undergo the first round of reviews.

DCFS and DMH staff have been identified to receive QSR protocol training on June 24-25, 2010. The first "pilot" review test is scheduled June 28 – July 2, 2010 in the DCFS-Belvedere Office.

Summary Highlights

During the last three months, the County has continued to demonstrate significant progress toward meeting the goals of the Strategic Plan and fulfilling the County's obligations related to the Katie A. Settlement Agreement. Significant highlights from the last report include:

- Revision of the MHST screening tool and DCFS/DMH related policies and procedures. A detailed timeline was established for the revised roll out of the MHST training across the 18 DCFS Regional Offices, beginning with the Belvedere and Santa Fe Springs Offices in August 2010. Katie A. management from DCFS, DMH, and CEO met with the Service Employees International Union Local 721 in May 2010 to discuss the revisions to the MHST. In June, a follow-up letter was submitted to the union indicating that since no feedback had been received on the forms that implementation of the revised MHST would go forward as discussed;

- A draft QSR instrument/protocol and scoring criteria have been developed collaboratively with the Katie A. Panel and the instrument will be piloted June 28 - July 1, 2010 in the DCFS Belvedere office. This is a momentous achievement for the County and an incremental step forward in fulfilling the exit criteria from the Katie A. lawsuit;

- Agreement with the Katie A. Panel on a set of Safety and Permanency Exit Indicators and targets to serve as exit criteria;

- Development of the Core Practice Model and Enhanced Skill-Based Training Curriculum; and

- Infusion of the children's mental health system with Mental Health Services Act Prevention and Early Intervention funding and transformation of a portion of general EPSDT allocations to promote the development of a set of evidence-based mental health practices.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Kathy House, Acting Deputy Chief Executive Officer at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

WTF:KH:LB
AM:hn

c: Executive Office, Board of Supervisors
County Counsel
Department of Children and Family Services
Department of Mental Health